APPEAL NO. 111877
FILED FEBRUARY 6, 2012

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). A contested case hearing (CCH) was held on October 4, 2011, with the record closing on November 18, 2011, in [City], Texas, with [hearing officer] presiding as hearing officer. The hearing officer resolved the disputed issues by deciding that: (1) the appellant (claimant) reached maximum medical improvement (MMI) on July 17, 2010, with an impairment rating (IR) of 0% and (2) the first certification of MMI and IR from [Dr. S] on July 17, 2010, did not become final under Section 408.123. The claimant appealed, disputing the hearing officer's determinations on MMI and IR, contending that Dr. S, the designated doctor, did not rate the compensable injury according to the rating criteria of the Guides to the Evaluation of Permanent Impairment, fourth edition (1st, 2nd, 3rd, or 4th printing, including corrections and changes as issued by the American Medical Association prior to May 16, 2000) (AMA Guides) and her narrative report did not meet the requirements as provided in 28 TEX. ADMIN. CODE § 130.1(c)(3)(A-D) (Rule 130.1(c)(3)(A-D)). The respondent (carrier) responded, urging affirmance of the hearing officer's determinations on MMI and IR. The hearing officer's determination that the first certification of MMI and IR assigned by Dr. S on July 17, 2010, did not become final was not appealed and has become final pursuant to Section 410.169.

DECISION

Reversed and rendered.

The parties stipulated that on [date of injury], the claimant sustained a compensable injury and that the Texas Department of Insurance, Division of Workers' Compensation (Division) appointed Dr. S as the designated doctor with regards to MMI and IR. There are two certifications of MMI and IR in evidence. There is one from Dr. S and another from [Dr. T], a doctor selected by the treating doctor to act in place of the treating doctor. The hearing officer found that Dr. S's date of MMI of July 17, 2010, and 0% IR were performed in accordance with the AMA Guides and were not contrary to the preponderance of the evidence. It was undisputed that Dr. T examined the claimant on June 6, 2011, and certified a clinical MMI date of November 11, 2009, with 25% IR.

MMI

Section 401.011(30)(A) defines MMI as "the earliest date after which, based on reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated." Section 408.1225(c) provides that the report of the designated doctor has presumptive weight, and the Division shall base

its determination of whether the employee has reached MMI on the report of the designated doctor unless the preponderance of the other medical evidence is to the contrary.

Dr. S examined the claimant on July 17, 2010. In her narrative report dated July 17, 2010, attached to her Report of Medical Evaluation (DWC-69), Dr. S reported the mechanism of injury as the claimant "was mixing lime and water in a blender and when he went to discard the mixture it blew out and knocked off his safety glasses. [The claimant] indicated he sustained burns to both his eyes." Dr. S diagnosed the claimant's work injury as "[a]lkaline chemical burn both eyes-cornea and conjunctival sac." Dr. S does not include in her narrative what medical records she reviewed for her certifying examination. Under the section entitled "[MMI], Dr. S stated that "[i]t is my opinion the [claimant] has reached [MMI] and did so effectively on [July 17, 2010]." Other than that being the date of the certifying exam, there is no explanation given for Dr. S selecting July 17, 2010, for the date of MMI.

Also in evidence were medical reports dated from [date of injury], through August 18, 2010, from [Dr. R], the claimant's treating doctor. These medical reports listed the same prescription ocular medications from May 2009 through August 2010 for the claimant; documented a change of contact lens bandages and a replacement of contact lens in July of 2009; and noted a discussion by Dr. R with the claimant about cataract surgery during the office visit of July 24, 2009, but Dr. R's opinion that surgery was not indicated. In a medical record dated May 19, 2010, Dr. R stated that upon examination of both eyes, a condition of blurring, associated with daily activity and chores had a gradual onset about a year earlier and affected both near and far vision and that the claimant had intermittent dry eyes. Dr. S stated that the blurring condition was stable. Dr. R documented said condition earlier in his report dated November 11, 2009, in which he indicated the condition was stable. No change in treatment plans or discussion of anticipation of further material recovery from or lasting improvement to the claimant's eye injury was documented in Dr. R's medical records in evidence from November 11, 2009, through August 18, 2010.

Dr. T, an ophthalmologist, examined the claimant on June 6, 2011, and certified that the claimant reached MMI on November 11, 2009. Dr. T listed his review of Dr. R's medical records in evidence dating from [date of injury], through August 18, 2010. In his narrative report dated June 6, 2011, attached to his DWC-69, Dr. T described the mechanism of injury the same as Dr. S. Dr. T, consistent with Dr. S, note there was no diagnostic test to review and the claimant had no surgery performed on either eye. In the section entitled "[MMI] Determination: [November 11, 2009]," Dr. T stated:

Given by [Dr. T] as [November 11, 2009] on review of the records of visual stability and maximum expected corneal injury healing, especially the right eye. This is different from the designated doctor [Dr. S] who stated it was on the date of her examination of [July 17, 2010]. That would make the healing process over 14 months for the eyes to heal from the time of injury. This ophthalmologist considers 6 months as the maximum time of healing to MMI in these injured eyes by alkali.

Further, in his testimony at the CCH, Dr. T stated that he considered that there was no further physical therapy to be done, no pending surgeries or transplants, or glaucoma medicines to be used in selecting the date of MMI that he certified.

Because the evidence established that on November 11, 2009, the claimant's medical condition was listed as stable by his treating doctor and because no further material recovery from or lasting improvement to the claimant's injury could reasonably be anticipated, the hearing officer's determination that the claimant reached MMI on July 17, 2010, as certified by Dr. S, the designated doctor, is so against the great weight and preponderance of the evidence as to be clearly wrong and manifestly unjust. The preponderance of the medical evidence supports that the claimant reached MMI on November 11, 2009, as certified by Dr. T, the doctor selected by the treating doctor to act in place of the treating doctor. Therefore, we reverse the hearing officer's determination that the claimant reached MMI on July 17, 2010, and render a new decision that the claimant reached MMI on November 11, 2009.

IR

Section 408.125(c) provides that the report of the designated doctor shall have presumptive weight, and the Division shall base the IR on that report unless the preponderance of the other medical evidence is to the contrary, and that, if the preponderance of the medical evidence contradicts the IR contained in the report of the designated doctor chosen by the Division, the Division shall adopt the IR of one of the other doctors.

Rule 130.1(c)(3) provides in pertinent part that the assignment of an IR shall be based on the injured worker's condition as of the MMI date considering the medical record and the certifying examination and the doctor assigning the IR shall:

(A) identify objective clinical or laboratory findings of permanent impairment for the current compensable injury;

(B) document specific laboratory or clinical findings of an impairment;

(C) analyze specific clinical and laboratory findings of an impairment;

compare the results of the analysis with the impairment criteria and provide the following:

(i) [a] description and explanation of specific clinical findings related to each impairment, including [0%] [IRs]; and

(ii) [a] description of how the findings relate to and compare with the criteria described in the applicable chapter of the AMA Guides. The doctor's inability to obtain required measurements must be explained.

See Appeals Panel Decision (APD) 110219, decided April 26, 2011.

Given that we have reversed the hearing officer's determination that the claimant reached MMI on July 17, 2010, and rendered a new decision that the claimant reached MMI on November 11, 2009, we reverse the hearing officer's determination that the claimant's IR is 0% as assigned by the designated doctor. Dr. S did not assign an IR based on the injured worker's condition as of the MMI date, November 11, 2009, considering the medical record and the certifying examination. We further note that Dr. S's IR could not be adopted regardless because Dr. S only provided measurements for the claimant's visual acuity with and without glasses for each eye. Dr. S failed to follow the steps as provided in Chapter 8 of the AMA Guides, page 8/217, in determining the impairment of the claimant's visual system and whole person. *See* APD 060949, decided June 21, 2006.

The only certification of MMI and IR with the rendered MMI date of November 11, 2009, is the assigned IR from Dr. T. Dr. T's DWC-69 reflected that the claimant's clinical MMI date is November 11, 2009, and his IR is 25% based on the AMA Guides. Dr. T outlined in his narrative report the steps that he undertook to determine the claimant's impairment of the visual system and of the whole person as described in the AMA Guides on page 8/217. Dr. T attached his worksheet that detailed his assignment of impairment of both eyes and there is no evidence that Dr. T did not follow the rating criteria as provided by Chapter 8 of the AMA Guides. Dr. T also testified that in his opinion the claimant's condition was as good as it was going to get, with little fluctuation, as of his certified MMI date of November 11, 2009.

Therefore, the hearing officer's determination that the claimant's IR is 0% is so against the great weight and preponderance of the evidence as to be clearly wrong and manifestly unjust. We reverse the hearing officer's decision that the claimant's IR is 0% and render a new decision that the claimant's IR is 25%.

The true corporate name of the insurance carrier is **FIDELITY AND GUARANTY INSURANCE COMPANY** and the name and address of its registered agent for service of process is

CORPORATION SERVICE COMPANY
211 EAST 7TH STREET, SUITE 620
AUSTIN, TEXAS 78704-3218.

Cynthia A. Brown
Appeals Judge

CONCUR:

Thomas A. Knapp
Appeals Judge

Margaret L. Turner
Appeals Judge